



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

STONEGATE SURGERY CENTER

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-16-0373-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

OCTOBER 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed 24666 to allow at 153% of Medicare fee schedule, which means we are expecting reimbursement for the implant C1776 per TDI guidelines. The reimbursement for these codes are 24666 at \$6,188.88 and C1776 6054.40."

Amount in Dispute: \$1,567.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The ASC service portion for code 24666 multiplied by 235 percent is \$3,852.99 (and not \$6,188.88 as the requestor asserts). The ASC device portion, invoice amount plus 10%, is \$6054.40. This totals \$9,907.39. Texas Mutual paid \$10,745.03. No additional payment is due."

Responses Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13, 2015	Ambulatory Surgical Care for CPT Code C1776	\$1,567.81	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
- 217-The value of this procedure is included in the value of another procedure performed on this date.
- 305-The implant is included in this billing and is reimbursed at the higher percentage calculation.
- CAC-45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.
- Payment was allowed using the device intensive method.
- CAC-18-Exact duplicate claim/service.

Issues

1. Is the allowance of CPT code C1776 included in the allowance of code 24666?
2. Is the requestor entitled to additional reimbursement for code C1776?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code C1776 based upon reason codes "CAC-97" and "217."

28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

On the disputed date of service, the requestor billed CPT code 24666-RT and C1776.

Per the National Correct Coding Initiative Edits, CPT code C1776 is not global to code 24666-RT; therefore, the respondent's denial based upon reason codes "CAC-97" and "217" is not supported.

2. Per the letter requesting reconsideration the requestor states "We billed 24666 to allow at 153% of Medicare fee schedule, which means we are expecting reimbursement for the implant C1776 per TDI guidelines. The reimbursement for these codes are 24666 at \$6,188.88 and C1776 6054.40." The Division concludes that the requestor supported that separate reimbursement for the implants was requested.

28 Texas Administrative Code §134.402(f)(2)(B)(i) and (ii) states, "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission; and (ii) the ASC service portion multiplied by 235 percent."

A. To determine the MAR for code 24666-RT and C1766 is a five-step process:

Step 1-Gather factors:

- According to Addendum B found on CMS website, the hospital outpatient prospective payment amount for code 24666 is \$5,569.47.
- The device dependent APC offset percentage for code 24666 is 43%.

- According to Addendum AA found on CMS website, CPT code 24666 has a Medicare fully implemented ASC reimbursement of \$4,138.76.
- The Core Based Statistical Area (CBSA-City Wage Index) located on the White House/OMB website or CMS website for Austin, Texas is 0.9545.

Step 2- To determine the device portion, you multiply the hospital outpatient prospective payment amount times the device dependent APC offset percentage:

\$5,569.47 multiplied by 43% = \$2,394.87.

Step 3 - Find the geographically adjusted Medicare ASC reimbursement for code 24666. This step requires calculations:

- The Medicare fully implemented ASC reimbursement rate of \$4,138.76 is divided by 2 = \$2,069.38.
- This number multiplied by the City Wage Index for Austin, TX $\$2,069.38 \times 0.9545 = \$1,975.22$.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement
 $\$2,069.38 + \$1,975.22 = \$4,044.60$.

Step 4- To determine the service portion:

- Subtract the device portion from the geographically adjusted Medicare ASC reimbursement
 $\$4,044.60 \text{ minus } \$2,394.87 = \$1,649.73$.
- Multiply the service portion by the DWC payment adjustment factor of 235%
 $\$1,649.73 \text{ multiplied by } 235\% = \$3,876.86$

Step 5- To determine the implant portion:

- Per submitted invoice the total charges for implants used in surgery is \$5,504.00. This amount multiplied by 10% = \$6,054.40.

Per 28 Texas Administrative Code §134.402(f)(2)(B)(i) and (ii), the MAR for services rendered on April 13, 2015 is $\$3,876.88 + \$6,054.40 = \$9,931.28$. The respondent paid \$10,745.03. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/29/15 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.